United Healthcare

Medicare Prescription Payment Plan Participation Request Form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January–December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Scan this code to save time and complete your request online.

Complete all fields unless marked optional.

First name	Last name	Middle initial (optional)

Medicare number

Birth date (MM/DD/YYYY)	Phone number
(_____/_____/_____)	( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness)

City	County (optional)	State	ZIP code

Mailing address, if different from your permanent address (P.O. Box allowed)

Address	City	State	ZIP code

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. My plan will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the terms and conditions listed below.
- **My plan will send me a letter to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature	Date

Participation terms and conditions

If your request is approved:

- You will no longer pay the pharmacy when you fill your Medicare-covered Part D prescriptions. Your plan will pay your cost share and send you a monthly bill.
- You understand that your Medicare Prescription Payment Plan monthly billing amounts may vary.
- You understand that failing to pay your Medicare Prescription Payment Plan monthly bill in full may result in your removal from the program.
- You may opt out of this program at any time and go back to paying the pharmacy directly for your Medicare-covered Part D medications. You will still be responsible to pay any outstanding Medicare Prescription Payment Plan balance.

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under state law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name	Address (street, city, state, ZIP code)
Phone number ( )	Relationship to participant

How to submit this form

Submit your completed form to:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Questions? We're here to help.

Call Customer Service at the toll-free number for members on your member ID card.